Health Insurance Advisory Council

January 16, 2007

5 – 6:30 PM – DBR Hearing Room

Minutes

Attendance:

Members: Annemarie Monks, Ed Quinlan, Domenic Delmonico, Howard Dulude, Peter Quattromanni, Bill Schmiedesknischt, Craig O'Connor, Bill Martin, Denise Lynn, Rick Brooks and Chris Koller (Co-Chairs)

Health Plans: Jim Joy, Jason Martesian, Ken Pariseau

OHIC Staff: Joe Torti, Jack Broccoli, Patricia Huschle, Adrienne Evans, John Cogan

Not in Attendance:Serena Sposato, Dawn Wardyga, Hub Brennan, MD, Elizabeth Walsh, Patrick Quinn,

1. Introductions

· Members of the Council and public attendees introduced themselves

2. Updates

· December 19, 2006, Minutes

· Approved with one change – Howard Dulude was not in attendance.

· Pending Direct Pay Hearing

· BCBSRI has filed for new rates for Direct Pay Product – average rate increase is 7.5%. Public hearing will be February 1. After testimony the Office will render a decision. The HIAC does not have a formal role in this process.

· Commonwealth Fund Article on health care costs, trends and future prospects

· Will be circulated to the HIAC as an informational piece. It is instructive.

3. Issue: United Extraordinary Dividend

· The purpose of this conversation was to get council feedback on the potential size of a United Health Care of New England Extraordinary Dividend and the nature of any investment by United in the state health care system as part of that dividend.

· Background (Joe Torti, Jack Broccoli and Chris Koller):

· Distinction between ordinary and extraordinary dividends.

· History of UHCNE negotiations with DBR, including DBR requirement for guarantee from United Health Group in late 90s, when UHCNE reserves were fragile. This has stayed in place and, additionally, United and UHCNE have a reinsurance arrangement in place now, under which United reinsures certain risks of UHCNE in exchange for a portion of UHCNE premium.

· Reserves Examination Report from last year (Lewin Report).

Indicated that recommended reserve ranges for UHCNE were difficult to calculate given corporate guarantee for UHCNE and existing reinsurance agreement. They did estimate reserves for a stand-alone company with the same characteristics of UHCNE.

· Data distributed comparing UHCNE reserves to other United subsidiaries, along with calculation of potential extraordinary dividend, given different reserve range targets.

· Statutory direction of the Office to "direct health plans towards policies that promote improved efficiency, access and quality" and implications of that on any request for dividends.

· Discussion:

· Size: Martin commented that comparing UHCNE to other subsidiaries would have to take into account additional guarantees and reinsurance arrangements in place here but not in place with other subsidiaries. The presumption is that since the reinsurance agreement transfers a significant portion of the risk to an affiliate UHCNE would not need as much capital to support is risks and could issue a larger extraordinary dividend to its shareholder.

· P. Quattromanni speculated on the effects of denying any dividend. Would this permit or force United to use its reserves for more in-RI uses (premium reduction. Provider payments, system investment) and fewer shareholder/United Health Group uses? Others noted that dividends are only one way to move money out of Rhode Island.

· Uses:

· D. Delmonico expressed two basic needs of the RI health system which might be greater than dividends to United shareholders and

where United could be considered to lag behind BCBSRI: Health Care IT investments and provider payments (especially to physicians).

· E. Quinlan noted that there was a history of plans "rebating" profits to providers – BCBSRI did this several years ago.

· J. Martesian of United indicated that United had been discussing increased IT investments in RI as it contemplated this request.

There was general consensus among Council members – articulated by R. Brooks - that any conditions attached to the extraordinary dividend approval be focused on investments in the system (to accomplish cost, quality and efficiency goals) rather than one time subsidies for providers or employers.

4. Transparency: Report of Provider/Health Plan Work Group

· Pat Huschle presented the Council with the initial findings of the group on the topic of how health plans are to make available facility-specific price and quality data to consumers of high deductible health plans. As discussed in previous HIAC meetings, this was a statutory charge to this group, which is accountable to the Council. The policy is that increased price and quality transparency will help consumers make better decisions and hold health care players more accountable. OHIC is seeking the Council's feedback on the Work Group's recommendations

· The draft full report was presented to the Council. Highlights include:

· Quality – support Department of Health efforts to do statewide provider quality reporting, rather than payer-specific quality

reporting.

· Withhold explicit provider-specific price information until provider-specific quality information is available.

· Price – until quality information is available, for high volume moderate cost procedures (not the most expensive or the least expensive) plans would show price ranges for a given geographic region. Within the region and price range, individual providers would have a "$" sign rating to show relative costliness.

· Ms. Huschle noted the hard work put in by the group and their willingness to wrestle with these issues.

· She clarified that prices might be displayed for a wider area than a zip code – not certain. Also, work would have to be done to define the services and include physician and hospital price components to make a fair comparison.

· Comments from the Council:

· B. Martin did not understand the need to withhold price information in the absence of quality. "Incomplete information is better than none – disclose as much as possible". You need to provoke the conversation.

· D. Delmonico thought it was a reasonable compromise between providers and health plans that are nervous about unintended consequences and misinterpretation and transparency advocates. Left unresolved are how to adjust price and quality for patient mix, provider training responsibilities and charity care subsidies.

· In response to a question, staff noted that data would reside on health plan web sites and they have an obligation to educate

consumers. Much of this information is available on the United Website if you know where to look.

· E. Quinlan noted that this seemed a reasonable compromise and was consistent with the Dept. of Health's work on provider Quality Measures. It is "a doable start".

· Several members noted it was important to place this effort in the context of other states' work. The Federal Medicare program has made a major commitment to posting more of this information.

· In response to a question, Ms. Huschle noted that the health plans had been participants in the workgroup and understood the recommendations, which will include a time frame for implementing these recommendations.

· "Will this make a difference?" the group was asked. Members of the council said, "It could not hurt" but needed to be seen as a first step – if it stopped at these price categories and had no quality probably not much change in patient or provider behavior would happen. "This is disruptive policy" said B. Martin, "It should be uncomfortable."

Staff thanked the Council for their feedback. It will be taken up with the work group and the full report will come back to the Council.

Next Meeting:

February 20, 2007

5 pm. DBR Hearing Room.

Topics

– Numerical Trends – Medicare, Medicaid, Uninsured and Commercial.

– Update and Feedback – Wellcare Product Development and Benefit Design. Implications for Broader Insurance Access.